STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. TARGET GROUP

Targeted Group: This target group consists of women aged 45 to 64 who are not residing in nursing homes and are not otherwise receiving case management services. The benefit will focus on women who are unaware of the importance of preventive services and the resources to receive those services.

D. DEFINITION OF SERVICES

See narrative D. in the section for Target Group P. This case management benefit will focus on early and ongoing screenings for breast cancer, cervical cancer, osteoporosis, diabetes and high blood pressure.

E. QUALIFICATIONS OF PROVIDERS

Providers of case management services to women aged 45 to 64 must be knowledgeable concerning the local service delivery system, the needs and dysfunctions of this recipient group, and the need for integrated services and the resources available.

Substitute Page

Supplement to 3.1A

(13) Consultations between or among providers, except as specified in HSS 107.06 (3).

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.04 Coverage of out-of-state services. All non-emergency out-of-state services require prior authorization, except where the provider has been granted border status pursuant to the provisions of section HSS 105.48 of this rule.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.05 Coverage of emergency services provided by a person not a certified provider. Emergency services necessary to prevent the death or serious impairment of the health of a recipient are covered services even if provided by a person not a certified provider. Such persons shall submit documentation to the department, to justify provision of emergency services, according to the procedures outlined in section HSS 105.05. The appropriate consultant(s) to the department shall determine whether a service was an emergency service.

HSS 107.06 Physicians services. (1) COVERED SERVICES. Physician's services covered by the medical assistance program are, except as otherwise limited in this rule, any medically necessary diagnostic, preventive, therapeutic, rehabilitative and palliative services provided in a physician's office, in a hospital, in a nursing home, in a recipient's residence or elsewhere, and performed by or under the supervision of a physician within the scope of the practice of medicine and surgery as defined by s. 448.01 (9), Stats. Such services shall be in conformity with generally-accepted good medical practice.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. [Note: For more information on prior authorization, see HSS 107.02 (3).] The following physician services require prior authorization in order to be covered under the medical assistance program:

(a) All covered physician services if provided out-of-state under non-emergency circumstances by a provider who does not have border status.

(b) All medical, surgical, or psychiatric services aimed specifically at weight control or reduction, and procedures to reverse such services.

(c) Surgical or other medical procedures of questionable medical necessity but deemed advisable in order to correct conditions that may reasonably be assumed to significantly interfere with a recipient's personal or social adjustment or employability.

(d) Prescriptions for amphetamines, Debrisan (Pharmacia Corp.) and Derifil (Rystan).

(e) Any covered physician service if federal financial participation is not provided.

Note: Federal financial participation means the federal funds available to the state to cover a portion of the cost of services provided under the state's Medicaid program. Federal financial participation is available for services which are federally-mandated Medicaid services (e.g., inpatient hospitalization, nursing home services, home health care, physicians services, drugs etc.). FFP is also available for services considered by the federal government to be optional in the Medicaid program (e.g., chiropractic). However, there are services and specific procedures for which FFP is not available, and in such instances, the cost of reimbursing the service must be picked up entirely by state funds.

(f) Ligation of internal mammary arteries, unilateral or bilateral.

(g) Radical hemorrhoidectomy, Whitehead type, including removal of entire pile bearing area.

(h) Omentopexy for establishing collateral circulation in portal obstruction.

(i) Kidney decapsulation, unilateral and bilateral.

(j) Perirenal insufflation.

(k) Nephropexy: fixation or suspension of kidney (independent procedure), unilateral.

(l) Circumcision, female.

(m) Hysterotomy, non-obstetrical, vaginal.

(n) Supracervical hysterectomy: subtotal hysterectomy, with or without tubes and/or ovaries, one or both.

(o) Uterine suspension, with or without presacral sympathectomy.

(p) Ligation of thyroid arteries (independent procedure).

(q) Hypogastric or presacral neurectomy (independent procedure).

(r) Fascia lata by stripper when used as treatment for lower back pain.

(s) Fascia lata by incision and area exposure, with removal of sheet, when used as treatment for lower back pain.

(t) Ligation of femoral vein, unilateral and bilateral, when used as treatment for post-phlebitic syndrome.

(u) Excision of carotid body tumor without excision of carotid artery, with excision of carotid artery, when used as treatment for asthma.

(v) Sympathectomy, thoracolumbar or lumbar, unilateral or bilateral, when used as treatment for hypertension.

(w) Splanchnicectomy, unilateral or bilateral, when used as treatment for hypertension.

(x) Bronchoscopy—with injection of contrast medium for bronchography or—with injection of radioactive substance.

(y) Basal metabolic rate (BMR).

(z) Protein bound iodine (PBI).

(za) Ballistocardiogram.

(zb) Icterus index.

(zc) Phonocardiogram with interpretation and report, and with indirect carotid artery tracings or similar study.

(zd) Angiocardiography, utilizing C02 method, supervision and interpretation only.

(ze) Angiocardiography—single plane, supervision and inter[illegible] tion in conjunction with cineradiography or—multi-plan, superv[illegible] and interpretation in conjunction with cineradiography.

(zf) Angiography—coronary, unilateral selective injection supervision and interpretation only, single view unless emergency.

(zg) Angiography—extremity, unilateral, supervision and interpretation only, single view unless emergency.

(zh) Fabric wrapping of abdominal aneurysm.

(zi) Extra-intra cranial arterial bypass for stroke.

(zj) Reversal of tubal ligation or vasectomy.

(zk) *Sterilizations.* 1. *Sterilization of a mentally competent individual aged 21 or older.* Sterilization is covered only if:

a. The individual is at least 21 years old at the time consent is obtained;

b. The individual is not a mentally incompetent individual;

c. The individual has voluntarily given informed consent in accordance with all the requirements prescribed in HSS 107.06 (3) (zk) 5. through 6. and

d. At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

2. *Mentally incompetent or institutionalized individual is not covered.* Sterilization of a mentally incompetent or institutionalized individual is not covered.

3. *Sterilization by hysterectomy.* a. A hysteretomy is not covered if:

i. It was performed solely for the purpose of rendering an individual permanently incapable of reproducing; or

ii. If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the indivudal permanently incapable of reproducing.

b. A hysterectomy enumerated in paragraph a. is covered only if:

i. The person who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will render the individual permanently incapable of reproducing; and

ii. The individual or her representative, if any, has signed a written acknowledgement of receipt of that information.

(a) Artificial insemination.

(b) Transsexual surgery. — 9 Covered 9/3/80

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

10. HSS 107.07 Dental services. (1) COVERED SERVICES. Covered dental services are those services, except where limited by this rule, which are provided by or under the supervision of a dentist or physician, within the scope of practice of dentistry, as defined in s. 447.02, Stats.

(a) Covered diagnostic procedures are those listed as follows:

1. Clinical oral examination and emergency diagnosis;

2. Radiographs:

a. Intraoral—(complete periapical series including bitewings or panoramic including bitewings);

b. Intraoral periapical—single, first film;

c. Intraoral periapical—each additional film—up to 9 films;

d. Intraoral—occlusal, single film;

e. Extraoral;

f. Bitewing films;

3. Tests and Laboratory Examinations:

a. Biopsy and examination of oral tissue (hard);

b. Biopsy and examination of oral tissue (soft).

(b) Covered preventive procedures are those listed below:

1. Dental Prophylaxis—scaling and polishing (including prophylaxis treatment paste if used);

2. Fluoride treatments—topical (excluding prophylactic treatment paste);

3. Space Maintainers—Fixed Unilateral, for premature loss of second primary molar only;

4. Recementation of space maintainer.

(c) Covered restorative procedures are those listed below:

1. Amalgam Restorations (includes polishing)—primary and permanent teeth;

2. Silicate Restorations, per restoration;

3. Acrylic, Plastic or Composite restoration;

4. Crowns, Single Restorations Only:

a. Stainless Steel, Primary Cuspid and Primary Posteriors only;

b. Stainless Steel—permanent teeth;

5. Other Restorative Services:

a. Recement inlay:

b. Recement crowns;

c. Retention pins per tooth;

d. Recement facings;

e. Sedative fillings.

(d) Covered endodontic procedures are those listed below:

1. Pulp Capping—includes bases but not final restoration;

2. Pulpotomy—includes base but not final restoration:

a. Therapeutic Pulpotomy—primary teeth only;

b. Vital Pulpotomy;

c. Pulpectomy in primary teeth;

3. Root Canal Therapy—gutta percha or silver points only:

a. Anterior (excludes final restoration);

b. Bicuspids (excludes final restoration);

c. Apexification or Therapeutic Apical Closure;

4. Periapical Services:

a. Apicoectomy, with Filling of Root Canal (Anterior and bicuspids only);

b. Retrograde filling;

c. Replantation and Splinting of Traumatically Avulsed Tooth.

(e) Covered Removable Prosthodontic procedures are those listed below:

1. Adjustments to Dentures (by other than dentist providing appliances);

2. Repairs to Dentures—(full dentures, partial dentures and reline allowances include adjustments for six-month period following insertion);

3. Other Prosthetic Services—Special tissue conditioning (in addition to relining and rebasing).

(f) Covered Fixed Prosthodontic procedures are those covered below:

1. Repairs:

a. Replace broken facing where post is intact;

b. Replace broken facing with acrylic;

c. Replace broken Tru-pontic;

d. Replace broken facing where post backing is broken;

2. Other Prosthetic Services—Recement bridge.

(g) Covered oral surgery procedures including anesthetics and routine post operative care are those listed below:

1. Simple extractions including sutures;

2. Surgical extractions:

a. Extraction of tooth—erupted;

b. Root recovery (surgical removal of residual roots);

c. Oral antral fistual closure (and/or antral root recovery);

3. Alveoloplasty (surgical preparation of ridge for dentures) — per sextant or quadrant in conjunction with extractions;

4. Surgical Excision—excision of reactive inflammatory lesions (scar tissue or localized congenital lesions; not hyperplastic tissue);

5. Excision of Tumors (not hyperplastic tissue);

6. Surgical Incision:

a. Incision and drainage of abscess—intraoral/extraoral;

b. Sequestrectomy for osteomyelitis;

7. Treatment of Fractures—Simple (maxillae, mandible, malar, alveolus and facial);

8. Treatment of Fractures—Compound or Comminuted (maxillae, mandible, malar, alveolus);

9. Reduction of Dislocation and Management of Other Temporo-mandibular Joint Dysfunctions;

10. Other oral surgery—suture of soft tissue wound or injury apart from other surgical procedure;

11. Other repair procedures:

a. Excision of pericoronal gingiva;

b. Closure of salivary fistula;

c. Emergency tracheotomy.

(h) Orthodontic records (applicable to orthodontic cases only).

(i) Covered adjunctive general services are those listed below:

1. Unclassified Treatment, Palliative (emergency) treatment, per visit;

2. Anesthesia, Local anesthetic, per quadrant (not in conjunction with oral surgery procedure);

3. Professional Visits, out of office:

a. House calls/nursing home calls;

b. Office visit, after regularly scheduled office hours (no operative services performed);

4. Drugs:

a. Pre-operative medication;

b. Post-operative medication.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION.

Note: For more information on prior authorization, see section HSS 107.02(3).

(a) The department may require prior authorization for covered dental services, where necessary to meet the program objectives stated in section HSS 107.02(3). A request for prior authorization of dental services submitted to the department by a dentist or physician shall identify at a minimum those items enumerated in section HSS 107.02(3)(d). In addition, the following shall be identified:

1. The age and occupation of the recipient.

2. Service or procedure requested.

3. When the service involves training in preventive dental care or orthodontics, or whenever requested by the department, an estimate of the fee associated with the provision of the service.

4. Diagnostic casts and/or radiographs may be requested by the department.

(b) In determining whether to approve or disapprove a request for prior authorization, the department shall consider the criteria enumerated in section HSS 107.02(3)(e) and, the cost of the service when necessary;

(c) The following dental services require prior authorization in order to be reimbursed under the medical assistance program:

1. All covered dental services if provided out-of-state under non-emergency circumstances by non-border status providers.

2. Surgical or other dental procedures of questionable dental necessity but deemed advisable in order to correct conditions that may reasonably be assumed to significantly interfere with a recipient's personal or social adjustment or employability.

3. Diagnostic Procedures—Temporomandibular Joint Radiographs.

4. Diagnostic Casts (other than requests for orthodontics)

5. Training in preventive dental care

6. Space Management Therapy:

a. Fixed Bilateral Type;

b. Removable bilateral type-acrylic.

7. Restorative Procedures:

a. Inlays, gold;

8.

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b. Crowns:

i. Plastic (acrylic) anterior teeth only—laboratory processed;

ii. Plastic with metal;

iii. Porcelain;

iv. Porcelain with metal;

v. Gold (full cast or 3/4 cast);

vi. Stainless Steel, laterals and centrals, primary teeth;

c. Metal post (dowel).

8. Endodontics (gutta percha or silver points only):

a. Molars (excludes final restoration);

b. Root Resection/Apicoectomy.

9. Periodontics:

a. Surgical (including post operative services):

i. Gingivectomy or Gingivoplasty;

ii. Gingivectomy, osseous or muco-gingival surgery;

iii. Osseous grafts;

iv. Osseous surgery;

v. Pedicle soft tissue graft;

vi. Vestibuloplasty;

vii. Gingival curettage and root planning;

b. Periodontics Adjunctive Services:

i. Provisional splinting—intracronal/extracronal;

ii. Occlusal adjustments (equlibration);

iii. Special periodontal appliances.

10. Prosthodontics (Removable, including 6 months post delivery care)—Note: If the request is approved, the recipient is required to be eligible on the date the authorized prosthodontic treatment is started. Once started, the service will be reimbursed to completion, regardless of the recipient's eligibility.

a. Complete dentures;

b. Partial dentures;

c. Denture Duplication (jump case) and Relining—(full dentures, partial dentures and reline allowances include adjustments for six-month period following insertion);

d. Other Prosthetic Services:

i. Obturator for surgically excised palatal tissue;

ii. Obturator for deficient velopharyngeal function (cleft palate);

11. Prosthodontics—Fixed;

12. Oral Surgery (including anesthetics and routine post-operative care):

a. Surgical Extractions:

i. Soft tissue impaction;

ii. Partial bony impaction;

iii. Complete bony impaction;

b. Other Surgical Procedures:

i. Surgical exposure of impacted or unerupted tooth for orthodontic reasons—including wire attachment where indicated;

ii. Surgical exposure of impacted or unerupted tooth to aid eruption;

c. Alveoloplasty not in conjunction with extractions;

d. Removal of cysts and neoplasms (odontogenic/nonodontogenic);

e. Surgical Incision:

i. Removal of foreign body from skin, or subcutaneous—areolar tissue;

ii. Removal of foreign body from hard tissues;

f. Excision of Bone Tissue (exostosis and partial ostectomy);

g. Reduction of dislocation and management of other temporomandibular joint dysfunctions:

i. Condylectomy;

ii. Meniscectomy;

iii. Injection of sclerosing agent or cortisone;

h. Other repair procedures:

i. Injection of trigeminal nerve branches for destruction;

ii. Osteoplasty (orthognathic deformities);

iii. Frenulectomy;

iv. Excision of hyperplastic tissue;

v. Excision of salivary gland;

15. Orthodontics—The diagnostic work-up is required to be performed and submitted with the prior authorization request. If the request is approved, the recipient is required to be eligible on the date the authorized orthodontic treatment is started. Once started, the service will be reimbursed to completion, regardless of the recipient's eligibility. Orthodontics are covered as required by federal regulation or, if necessary to prevent acute dental problems or irreversible damage to teeth or supporting structures.